Appendix 6 - Self Administration of Medication Assessment Form

Name: _____ Residence:_____
QMRP/Case Manager: _____ Nurse: _____
Evaluate the individual's ability to participate in a self-medication program by placing a check in the appropriate box and providing comments

TASK	Yes	No	SUPPORT NEEDED	COMMENTS
Responds when name is called			□ Requires physical prompt or gesture □ Other	
Time concept recognition □ am □ pm □ breakfast □ lunch □dinner/supper □ bedtime □day of week			□ Requires pictures to recognize correct time of day to receive medication □ Other	
Understands basic number concepts and is able to count from 1 to 3			□ Requires counter or assistance from staff □ Other	
Identifies different colors			□ Requires picture to reference pill shape □ Other	
Discerns different shapes			□ Requires picture to reference pill shapes □ Other	
Identifies his/her name on medication bottle/drawer			□ Requires special sticker/ symbol to recognized personalized medication container □ Other	
Names medication s/he receives			□ Needs to write medication name to verify	
Knows correct dosage of medication			□ Requires prompts	
Opens and closes medication containers			□ Needs assistance	
Pours correct dosage of medication			□ Needs assistance	
Obtains an adequate amount of medication			□ Needs assistance	
Puts medication in mouth			□ Needs assistance	
Obtains adequate amount of fluid to take medication			□ Needs assistance	
Writes name initials on MAR			□ Needs assistance	

Based on this evaluation and observation, place a check on the appropriate box for recommendation:

	Individual is not able to administer medication to him/her at this time and is not recommended for the "Self Administration of Medication" training program at this time.
	Individual is capable of self-administering medication w/ assistance and under close supervision. and/or hands on assistance. The individual will participate in the med. administration and will start an individual training program.
	The individual has the potential to self administer medication independently and safely. The individual is recommended by the team to start an individual training program.

Signature of RN completing assessment: _____ Date: _____
(__) Not recommended for self-medication program (__) Recommended for self medication program
Signature of Physician: _____ Date: _____